

# CAPITAL HEALTH PENSION PLAN

## BENEFICIARY DESIGNATION FOR PRE-RETIREMENT DEATH BENEFIT

### Beneficiary Information

I, \_\_\_\_\_, hereby designate the following as my beneficiary(ies) for my vested benefits under the Capital Health Pension Plan. I understand that if I am married and I designate a non-spouse primary beneficiary prior to the first day of the plan year (calendar year) in which I attain age 35, I must reaffirm my beneficiary election upon attainment of age 35 (unless I terminate employment prior to such date). I understand that my benefits will be distributed to my contingent beneficiary(ies) only if none of my primary beneficiaries survive me.

*Note: If you are married and do not designate your spouse as primary beneficiary to receive 100% of your benefits upon your death, your spouse's notarized consent must be obtained on the second page of this form.*

#### Primary Beneficiary(ies)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

% of Benefit: \_\_\_\_\_

#### Contingent Beneficiary(ies)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

% of Benefit: \_\_\_\_\_

(Attach additional pages if you need more space for your beneficiary(ies). If your beneficiary is a trust, list the name and address of the trustee and the date the trust was executed.)

### Marital Status

Please indicate your marital status

- I am married (see next page)
- I am not married, or I am married but my spouse cannot be located.  
(If you marry in the future, or if you are married and your spouse is located prior to commencement of benefits, you must complete a new Beneficiary Designation Form.)

### Authorization

This designation supersedes any and all prior designations and shall be effective until such time as it is superseded by a subsequent designation or revoked. I understand that this designation shall be effective only after receipt by the Human Resources Department.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Received by Office

**CAPITAL HEALTH PENSION PLAN  
BENEFICIARY DESIGNATION FORM FOR PRE-RETIREMENT DEATH BENEFIT**

**Participant:** \_\_\_\_\_

**Instructions for Spousal Consent**

The Capital Health Pension Plan provides that, in the event of a participant's death before benefit payments begin, the participant's entire vested account balance is automatically payable to the participant's surviving spouse as a lump sum or survivor annuity, unless the spouse has consented to another beneficiary designation.

Have your spouse complete the following only if you are married and you have not designated your spouse as primary beneficiary to receive 100% of your benefits upon your death.

**Spousal Consent**

I, \_\_\_\_\_, understand that I have not been named by my spouse as sole primary beneficiary to receive pre-retirement death benefits payable under the Capital Health Pension Plan. I hereby consent to such designation and acknowledge its effect on me, namely, that upon my spouse's death, benefits payable under the Capital Health Pension Plan shall not be paid to me in a pre-retirement survivor annuity or in any other form (or, if I am a co-beneficiary, that portion of benefits payable to another co-beneficiary will not be paid to me). I understand that my consent to this designation of a beneficiary (or co-beneficiary) other than myself is irrevocable as to the individual so designated on the Beneficiary Designation Form.

\_\_\_\_\_  
Spouse's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witnessed by Notary Public

Revised September 2014